ORIGINAL COMMUNICATIONS

INCEST AND CHILD SEXUAL ABUSE

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Child sexual abuse was examined nationally and in the Washington, DC and Howard University Hospital area. In an attempt to describe this widespread problem, two case histories are presented which reflect some of the typical characteristics of child sexual abuse cases seen at Howard University Hospital. Pertinent literature is reviewed citing the prevalence rates and the personality and environmental factors which may contribute to the sexual abuse of children in this country. Finally, the role of the physician in identifying and treating the physical and emotional effects of child abuse are discussed.

Incest has been considered a taboo since the beginning of recorded history. It is defined as sexual intercourse between persons who are too closely related to legally marry. Various states have different laws defining who can legally marry, although, for the most part, marriage is prohibited between blood relatives closer than first cousins. Over the past several years, child physical abuse and child sexual abuse have received increased attention from the communications media and from the lay and professional press. In 1974, Congress approved the development of an office known as the National Center on Child Abuse and Neglect. The purpose of this center is to compile and analyze current research in the area of child abuse and neglect, maintain an information and clearing house on active programs, assist practitioners who are involved in prevention, identification and treatment of child abuse and neglect, provide technical assistance to those organizations developing treatment, prevention and identification programs, conduct research, and carry out epidemiological surveys.[1]

The tragedies of child abuse victims, however, remain daily occurrences throughout the United States. This paper describes some of the early diagnostic signs of child sexual abuse and reviews the treatment modalities currently available.

INCIDENCE

The actual incidence of incest is not known. Reporting of this condition is limited because of society's attitudes toward this very sensitive topic, the usual family disruption that it causes, threat of criminal punishment, and fear of ostracism by members of the community. Numerous estimates have been made; however, these figures simply underscore the fact that the victims reported represent the tip of the iceberg of a signifi-

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cant social and medical problem.

Santa Clara County, California has a program which services an area comprising approximately one million people; it reports 200 referrals annually.[2] National estimates by the Children's Division of the American Humane Association range from 1.9 to 40 cases per million population. According to a recent estimate of the National Center on Child Abuse and Neglect, a minimum of 100,000 cases of child sexual abuse occur annually in the United States. These estimates were based on actual reports of 3,000 cases in 1977, 6,000 cases in 1978, and 11,016 cases in 1979.[3]

In the District of Columbia, the Child Sexual Abuse Victim Assistance Project of the Children's Hospital National Medical Center reported 822 cases from 1978 to 1980. Ninety percent of the victims were residents of Washington, DC, and 10 percent were from the surrounding metropolitan area. Twenty-nine percent of the victims were male, and 71 percent were female. The age range was from 3 months to 18 years, and the average age was 8 years and 10 months. Twenty percent of the offenders were parents or parent surrogates. Twenty percent were male family members other than the father, 45 percent were people that the child knew, and only 15 percent were strangers.

At Howard University Hospital approximately 80 cases of child abuse were reported during the two-year period between 1978 and 1980. Of this number approximately 29 percent, or 23 cases, were instances of sexual abuse. Medical records of these sexually abused children indicated the following demography: (1) the age range was one month to 17 years; (2) the sex of the victims was almost equally divided between males and female; and (3) the relationship of the offender varied from parents to aunts, uncles, babysitters, neighbors, and friends of the family. The reported cases of actual incest were relatively small, but this may be due to the fact that the population that uses the Howard University Hospital includes a high percentage of nontraditional families. Most of the sexually abused children were not actually living with their fathers, the most frequent perpetrators of incest, although many males living or frequently visiting the home were reported to have sexually abused the children. The following case histories are typical of this pattern of sexual abuse found among the patients treated in our hospital for sexual abuse.

CASE HISTORIES

Case 1

Elizabeth (the name is fictitious), a seven-year-old black girl, was brought to the hospital by her aunt complaining of a thick, whitish, vaginal discharge. She was evaluated in the emergency room, where cultures of the discharge were obtained. There were no significant physical findings on examination which would indicate physical or sexual abuse or neglect. She appeared to be a healthy, well-cared-for child. She was discharged from the emergency room for outpatient treatment, and subsequent laboratory data revealed that her vaginal cultures were positive for Nieserria gonorrhea. She was treated appropriately with procaine penicillin, and her vaginal discharge ceased after several days.

On the next visit the mother accompanied her daughter, and a more complete social history was obtained. According to the mother, she and Elizabeth lived alone in an apartment. The mother was employed as a cashier and worked irregular hours. She frequently left Elizabeth in the care of her parents, brothers, and sisters who lived nearby. One of the most frequent visitors was Elizabeth's 17-year-old uncle, who occasionally babysat for her and often did odd jobs around the apartment. When Elizabeth's mother was informed that her child's vaginal discharge was caused by gonorrhea, she was angry with her daughter and unable to imagine how she could have contracted the disease. The mother recalled after closer questioning, however, that her 17-year-old brother recently had been treated for gonorrhea at another hospital.

Children and their families with positive tests for gonorrhea are often referred to the Child Protection Team. During an interview with a member of the Child Protection Team staff, Elizabeth stated that her 17-year-old uncle had "played" with her. Elizabeth's mother had difficulty accepting the fact that her brother could have had sexual intercourse with her daughter or that he had sexually manipulated her. She expressed significant guilt and anger and continued to verbalize the possibility that someone else in the household could have abused the child. She suspected that her boyfriend had molested Elizabeth and, at times, suspected other family members. These suspicions caused considerable disruption among the family members and close friends.

Because of the laboratory results and history, the Child Protection Committee voted to refer Elizabeth's case to the city authorities for further investigation. No charges were brought against the uncle since Elizabeth's mother declined to identify him as the offender and because the child's testimony was felt to be unreliable because of her young age. According to follow-up reports, however, the uncle is still a frequent visitor to the household, and all referrals for psychiatric therapy or family counseling were declined by Elizabeth's mother.

Comments and Treatment

Gonorrhea ranks first among all reported communicable diseases in the United States. Venereal diseases in children are usually acquired through sexual contact. This contact may be due to sexual abuse, but frequently children may acquire gonorrhea from a playmate while engaging in sex play or sexual experimentation. It is essential that the clinician take the same medical precautions with the child and the family as he/she would in any case of communicable disease. It is critical that we know where the child obtained the infection. Quite often, clinicians and family members are reluctant to discuss these matters with the children. Many clinicians feel that children usually respond better to direct questions, however, and that if the clinician can reduce his or her own anxiety about discussing the problem with the child, a more complete history will be obtained. This will make it possible for all parties to be treated and if, in fact, there has been an incident of sexual abuse, this matter may be investigated.

Gonorrhea may manifest symptoms such as vaginal discharge, as in the case with Elizabeth, but frequently, it may be seen as a rectal or pharyngeal infection or infection of the eyes due to spread from the initial site of exposure. It is helpful to do cultures of all orifices to ascertain the extent of the disease.

Often, other venereal diseases are transmitted during sex play or sexual abuse and the children should be tested for syphilis and other diseases such as herpes and pediculosis. Treatment regimens vary, but local public health departments, the American Academy of Pediatrics, and the Venereal Disease Control Advisory Committee of the Center for Disease Control, US Public Health Service recommend current dosages and regimens for the various agents causing the diseases.

When confronted with presenting symptoms of venereal diseases, clinicians treating children should be diligent in gathering their patient and family histories and eliciting the names of all possible contacts for treatment. In the District of Columbia, child abuse, sexual abuse, and venereal diseases are reportable by law to the local health department, but there is still significant reluctance on the part of many physicians to report these cases. For those clinicians who are reluctant because they are unsure of the evaluative or procedural processes, trained child protection teams can be of assistance, but they can do so only if clinicians call upon them.

Other physicians may not report cases of child abuse because they are reluctant to become involved for fear of their potential liability for unsubstantiated allegations and their fear that the patient may sue them. The District of Columbia law, however, grants legal immunity to physicians and professionals reporting cases of physical and sexual abuse to the Child Protective Service.

Case 2

John was referred for psychiatric treatment at age seven for soliciting oral and anal sex from his peers. This black male child attempted to set another child's clothing on fire, was felt to have effeminate mannerisms, and was doing poorly in school. John frequently was involved in violent verbal and physical fights with his parents and was alternately passive and withdrawn. He had been physically abused and neglected by his parents over a period of several years, and his mother allegedly had performed oral sex on him since age five.

Prior to the psychiatric referral, John had been diagnosed as suffering from psychosocial failure to thrive. It was reported also that he was terrified of his mother and of her violent, aggressive outbursts and frequent spankings. During subsequent interviews, John described ambivalent feelings toward his father and felt sure that his father did not like him because he acted like a "sissy."

John's father, on the other hand, had reportedly been physically abused by his own father. John's

mother was allegedly sexually abused repeatedly by her stepfather, beginning at age eight. His mother verbalized intense negative feelings toward her own father, stepfather, husband, and mother. She felt that her mother colluded with the stepfather in his sexual abuse of her. John's mother dropped out of school and left home at age 13. She allegedly became involved with drugs, promiscuous sexual activity, and shoplifting. These factors, in addition to her failure to establish meaningful relationships with anyone, reportedly contributed toward numerous suicide attempts.

John and his family were seen in psychotherapy for two years. This therapy included individual, group, and family treatment. According to his psychiatrist, John significantly matured over this two-year period and modified many of his previous behaviors. He no longer identified with his mother and mimicked her feminine mannerisms. He was appropriately assertive, was no longer fearful of his mother, and was more outgoing and involved with other children. He was now also able to become involved in male oriented sports. His sexual promiscuity ceased, and he no longer solicited sexual relationships with other children. His grades improved to A's, and he surprised his parents by earning a good friendship award from his school. Not only did John mature over this period, but his parents also matured during therapy to the point that their marital relationship significantly improved, and they attempted to modify their negative child rearing practices.

Comments and Treatment

This case demonstrates a somewhat typical instance of multigenerational child sexual abuse in which parents who are physically or sexually abused themselves as children are frequently observed to abuse their own children in a similar fashion. It also highlights the fact that males, as well as females, are victims of sexual abuse. Treatment of this multigenerational pattern of child abuse and incest involves the entire family and out of necessity must, therefore, continue for several months and sometimes even several years. Families who have been involved in multigenerational child sexual abuse and decline counseling or psychotherapy often are doomed to continue these patterns of violent and defiant sexual behavior. Voluntary outpatient treatment programs are effective only for some of the individuals involved. In other cases, the offenders must be institutionalized. Unfortunately, this often serves as a mere protective function.

DISCUSSION

The Child Sexual Abuse Treatment Program (CSATP), developed by Giarretto, outlines a program of treatment which has been found to be effective in his population.[4] His therapeutic approach is based upon the theory and methods of humanistic psychology which were founded by Assagioli and others. In general, this model proposes to alleviate the emotional stresses involved in cases of sex abuse and incest, eliminate punitive actions by the community, enhance the process of self-awareness and self-management, promote family unity and growth and promote a sense of responsibility to society. Their stated purpose is not to extinguish or modify dysfunctional behavior via external devices, but to help each client develop the habit of self-awareness and the ability to direct his own life. The treatment procedure used was as follows: "(1) individual counseling, particularly for the child, mother, and father; (2) mother-daughter counseling; (3) marital counseling, which becomes a key to treatment if the family wishes to be reunited; (4) father-daughter counseling; (5) family counseling; and (6) group counseling. The treatments are not listed in order of importance, nor followed invariably in each case, but all are required for family reconstitution" in their experience.[4]

Giarretto's work has been modified and expanded upon in several programs throughout the country. It is important for the clinician to remember, however, that treatment needs will vary with each specific case. Locally, the Children's Hospital National Medical Center has a 24-hour hot line which serves to provide information and advice on management to clinicians who suspect a case of child sexual abuse. The police sex squad also will respond to inquiries, but, in general, their assistance is formal. If a clinician calls the sex squad and gives specific information, they will send an officer to investigate the complaint. The results of this investigation would determine their next step,

which could include the arrest of the alleged offender. The police department has the option to bring all of the involved parties to the sex squad office and complete its investigation, but once this step has been taken, it is difficult for the physician to maintain rapport with the victim's family since legal steps are usually in progress by this time.

Treatment, then, by identifying early warnings of physical abuse, venereal infection, and precocious sexual play or conversation with young children is only one step in the control of this problem. Seeking expert information from child protection committees of local hospitals or the local police departments is an additional method of beginning to cope with the problem, and making formal complaints to child protection agencies is, of course, the legal and ethical responsibility of each clinician. We vary in our ability and enthusiasm in going through the process of treating cases of child sexual abuse. Thus, for all involved, it would seem that prevention is clearly the more viable option.

Sgori has stated that for prevention to occur at least one adult member of the family must recognize that the threat of incest can exist in almost any family unit.[5] After this threat has been recognized, the individual must go one step further and take some action to prevent it from actually occurring. Once these steps have been taken, the parents or responsible adults should make an active effort to foster attitudes and behaviors that would tend to enhance various family members' social roles and to delineate boundaries within the family structure. Parents, or parent surrogates, should also overtly confirm the exclusiveness of their relationship and should recognize and, perhaps, verbalize the normalcy of some of the feelings that various members of the family may be experiencing for one another.

Rosenfeld[6] describes several factors he believes to be acceptable boundaries, recognizing that cultures and subcultures vary widely in their acceptable standards of family sex life and that these standards and values often change over time. For example, in the United States, we are in a period of rather dynamic change at this point in history. According to Rosenfeld, normal sex life in the home should include:

(1) no attempt by the parents to satisfy their adult, genital sexual needs through their children; (2) no seduction or overstimulation of the child; (3) an ability to tolerate social and personal intimacy between parents and children without actual sexual involvement; (4) a culturally acceptable degree of warmth, affection and stimulation without either discomfort or inhibition in doing what is usual, or disregard for sub-cultural standards. To provide this, parents must be comfortable with these standards; (5) adequate privacy for both parents and children in overt sexual matters, but a willingness on the parents' part to transmit honest information about sex to their children. This information should be consistent with the parents' personal and cultural standards; and (6) an ability to change and adopt family practices so that they remain suited to the child's changing age and stage of psychosexual development.[6]

It is important to remember that the kinds of psychological scarring resulting from these sexually traumatic events may not present themselves for several years and that problems with frigidity, depression, uncontrolled violence and rage, and other antisocial behaviors are often merely expressions of outrage at the betrayal and insecurity that the child had to endure as a victim of sexual and often physical abuse. Prevention, then, is clearly more palatable than treatment after the event. If clinicians become more aware of the scope of this problem and are less reluctant to become involved initially, much human suffering may be eliminated and our understanding of this phenomenon will be improved greatly.

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